

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/15/2011
NAME OF PROVIDER OR SUPPLIER DUKES MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 275 W 12TH ST PERU, IN 46970		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for a standard licensure survey.</p> <p>Facility Number: 005062</p> <p>Survey Date: 12/14-15/2011</p> <p>Surveyors: ReBecca Lair, LCSW Medical Surveyor</p> <p>Jacqueline Brown, RN Public Health Nurse Surveyor</p> <p>Lynnette Smith, Medical Surveyor</p> <p>Dukes Memorial Hospital is in compliance with 410 IAC15.1, Hospital Licensure Rules.</p> <p>QA: cloughlin 12/21/11</p>	S 000			

Indiana State Department of Health

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

9K1811

If continuation sheet 1 of 1